DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS STREET ADDRESS, CITY, STATE ZIP CODE 302 ST JOSEPH ROAD NEW ALBARY, IN 47150 PREPIX TAG FREGULATION CONTROL OF DEPICIENCIES TAG INITIAL COMMENTS F 000 INITIAL COMMENTS INITIAL COMMENTS	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS STREET ADDRESS. CITY, STATE, ZIP CODE 3925 ST JOSEPH ROAD (A)410 (A)410 (A)410 (B)410 (B			155488	B. WING			C 06/02/2011	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS This visit was for the Investigation of Complaint IN00090809 and Complaint IN00090809 substantiated, no deficiencies related to the allegations are cited. Complaint IN00091220 Substantiated, no deficiencies related to the allegations are cited. Survey dates: May 31, June 1, and 2, 2011 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Survey team: Anne Marie Crays RN Census bed type: SNFANE: 111 Total: 111 Census payor type: Medicare: 14 Medicare: 14 Medicare: 14 Medicare: 15 Medicare: 15 Medicare: 14 Medicare: 15 Medicare: 14 Medicare: 15 Medicare: 14 Medicare: 15 Medicare: 14 Medicare: 15 Medicare: 16 Medicare: 17 Kindred Transitional Care and Rehab-Rolling Hills was found to be in compliance with 42 CFR Part 433 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN000901220. Quality review completed 6-3-11 Cathy Emswiller RN					STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH ROAD			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
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